

Illinois Department of Public Health

(X8) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006118</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>05/13/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>METROPOLIS REHAB &amp; HCC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2299 METROPOLIS STREET METROPOLIS, IL 62960</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	Continued From page 1  injury or change in condition at the time of notification.  Section 300.1210 General Requirements for Nursing and Personal Care  b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.  Section 300.3240 Abuse and Neglect  a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)  THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:  Based on record review and interview, the facility failed to notify the physician, residents legal representative and/or interested family member in a timely manner of a change in condition, and/or of a pharmacy consult drug interaction concern for 2 of 15 residents ( R3, R15) reviewed for physician notification in the sample of 15. In addition, the facility also failed to provide identified nursing services for one resident (R15) reviewed for nursing services in the sample of 15. This failure resulted in R15 being transferred to local hospital.  The findings are:	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006118</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>05/13/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>METROPOLIS REHAB &amp; HCC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2299 METROPOLIS STREET METROPOLIS, IL 62960</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	Continued From page 2  1. R15's Vital Summary for March 2016 for 3/17/16 at 2:31 AM shows R15's pulse was 56 (irregular-New onset). No documentation could be found that R15's doctor, Power of Attorney or family was made aware of new onset of irregular, low heart rate.  R15's Health Status note on 3/18/16 at 2:30 AM shows resident was having wet sounding cough and complained of hard time breathing and was experiencing chest pain that was continuous and non-radiating and in the center of her chest and held her right hand in a fist over the area at mid-neck line between her breast. R15 stated she felt like she should go to the hospital. Nurse did not send R15 to hospital at that time but gave R15 an antacid and informed R15 that chest pain may subside in a few minutes. R15's documents go on to show that the nurse went back to the nurse station to resume charting. CNA(Certified Nursing Assistant) went back to check on R15 per nurse request and when CNA entered room came back out and summoned nurse. When nurse arrived R15's eyes were open and her gaze was becoming fixed, weak pulse at 2:50 AM CPR(Cardiopulmonary Resuscitation) and chest compressions were started and continued until Emergency Medical Services arrived. This document goes on to state that hospital informed facility of R15's death at 3:44 AM.  There was no documentation found in R15's chart regarding making her doctor, Power of Attorney or family aware of changes in condition and her request to go to the hospital.  R15's mental assessment done on 02/24/16 is a 15 out of 15 which makes her capable of making her needs known and making her own decisions for her care.	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006118</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>05/13/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>METROPOLIS REHAB &amp; HCC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2299 METROPOLIS STREET METROPOLIS, IL 62960</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S9999	Continued From page 3  On 5/13/16 at 11:00 AM Z1(Primary Care Physician) stated the expectation would be that the staff would notify him or someone from his office if there was a change in the resident and/or if there was a change in the normal status of a resident or their condition. Z1 stated the facility will notify him often of different things by fax and call him but could not remember being made aware of R15's irregular 56 heart rate on 3/17/16. Z1 stated the notification would not have necessarily changed the outcome of R15 having a Cardiac Arrest and subsequent death on the early hours of 3/18/16, because R15 had such a long extensive history of cardiac and pulmonary issues.  On 5/12/16 at 4:00 PM, E4(Corporate Nurse) stated the expectation is that if there's a change in condition in a resident then the nurse should be notifying the doctor and the POA(Power of Attorney). E4 stated the nurse that had taken care of R15 in the early morning of 3/17/16 and 3/18/16 should have called and made the physician aware of R15's condition. E4 stated she had spoken to the nurse that had taken care of R15 on the night of 3/17/16 and it was also the same nurse that took care of R15 on 3/18/16. E4 stated she had asked the nurse why she had not notified the doctor of R15's irregular pulse on 3/17/16 and E4 stated the nurse did not have an answer. E4 stated she also asked the nurse if on the early morning of 3/18/16 had she taken vital signs, assessed her lungs, or if the nurse even did a general assessment or why she did not send R15 to the hospital at that time of her request. E4 stated the nurse could not answer any of those questions's when asked. E4 stated this nurse no longer worked for the facility because she was terminated for not following	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6006118	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/13/2016
NAME OF PROVIDER OR SUPPLIER  METROPOLIS REHAB & HCC		STREET ADDRESS, CITY, STATE, ZIP CODE 2299 METROPOLIS STREET METROPOLIS, IL 62960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4  policies and procedures.  R15's Health Status note on 3/18/16 shows "at approximately 2:30 AM resident turned on her call light. A CNA(Certified Nursing Assistant) answered the call light immediately. The CNA reported to this nurse that the resident not feeling well. This nurse went in to residents room and discovered resident was lying flat in bed in supine position with her head upon a pillow. Nurse noticed wet sounding cough and resident was holding a trash can and spitting into it. At this time resident was alert and speaking to nurse describing how she felt. Resident reported to nurse that she was having a hard time breathing due to cough. Nurse adjusted resident with the assistance of 2 CNA's who came into the room at this time. HOB (Head of bed) was elevated. Resident described experiencing chest pain that was continuous and non-radiating. She described location "in the center" of her chest and held her right hand in a fist over the area of mid-neck line between her breast. She stated she felt like she should go to hospital. This nurse went to med.(medication) cart and obtained a antacid and gave it to resident. Nurse instructed resident to chew antacid up in her mouth and swallow it. Resident nodded her head in understanding. Nurse informed resident that her chest pain may subside in a few minutes and that nurse was going to leave the room for just a minute. Resident nodded. Nurse came to nurses station and resumed charting on another resident, nurse also asked CNA at nurse station to go check on resident and to ask her if she was feeling any better. CNA went to resident room and stepped back out into hallway and said, "I can't understand her, come like now!" Within seconds, nurse was heading to resident's room. Upon arrival, resident had her eyes open and her	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006118</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>05/13/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>METROPOLIS REHAB &amp; HCC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2299 METROPOLIS STREET METROPOLIS, IL 62960</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S9999	Continued From page 5  gaze was becoming fixed. This nurse called out residents name and resident attempted a vocal response. A Weak pulse was noted. Nurses stepped out of room to call 911, and another nurse to aid in CPR if necessary. Continued to get a response from resident. Two nurses met in resident's room and find resident unresponsive to CNA attempts to keep alert. Apnec breathing noted at this time. Sternal rub elicited a response from resident 2 possibly 3 times. Nurses begin CPR with chest compressions starting at 2:50 AM and continued until EMS(Emergency Medical Services) arrived. CNA obtained oxygen and it was started at 4 liters per nasal cannula. Blood sugar was 191. This nurse spoke with local hospital around 4:00 AM and was informed that official time of death was 3:44 AM. On Call nurse notified, as well as family and MD."  There was no documentation found in R15's chart indicating that her doctor, Power of Attorney or family were made aware of changes in condition and her request to go to the hospital.  R15's mental assessment done on 02/24/ 16 is a 15 out of 15 which makes her capable of making her needs know and making her own decisions for her care.  On 5/13/16 at 11:00 AM Z1(Primary Care Physician) stated the expectation would be that the staff would notify him or someone from his office if there was a change in the resident or if there was a change in a normal status of a resident or their condition. Z1 stated the facility will notify him often of different things by fax and call him but could not remember being made aware of R15's irregular 56 heart rate on 3/17/16. Z1 stated the notification would not have necessarily changed the outcome of R15 having	S9999			



Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006118</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/13/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>METROPOLIS REHAB &amp; HCC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2299 METROPOLIS STREET METROPOLIS, IL 62960</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6  a Cardiac Arrest and subsequent death on the early hours of 3/18/16 because R15 had such a long extensive history of cardiac and pulmonary issues.  On 5/12/16 at 4:00 PM, E4(Corporate Nurse) stated the expectation is that if there's a change in condition of a resident then the nurse should be notifying the doctor and the POA(Power of Attorney). E4 stated the nurse that had taken care of R15 in the early morning of 3/17/16 and 3/18/16 should have called and made the physician aware of R15's condition. On 5/12/16 at 4:00 PM, E4(Corporate Nurse) stated the expectation is that if there's a change in condition of a resident then the nurse should be notifying the doctor and the POA(Power of Attorney). E4 stated the nurse that had taken care of R15 in the early morning of 3/17/16 and 3/18/16 should have called and made the physician aware of R15's condition. E4 stated she had spoken to the nurse that had taken care of R15 on the night of 3/17/16 and it was also the same nurse that took care of R15 on 3/18/16. E4 stated she had asked the nurse why she had not notified the doctor of R15's irregular pulse on 3/17/16 and E4 stated the nurse did not have an answer. E4 stated she also asked the nurse if on the early morning of 3/18/16 if she had taken vital signs, assessed her lungs, or if the nurse even did a general assessment or why she did not send R15 to the hospital at that time of her request.  R15's Brief Mental Health Assessment shows a score of 15 out of 15 and is able to make her own decisions.  R15's Medication Review for March 2016 shows she is a full code; orders for DuoNeb Solution	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006118</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>05/13/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>METROPOLIS REHAB &amp; HCC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2299 METROPOLIS STREET METROPOLIS, IL 62960</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	Continued From page 7  0.5-2.5 (3) mg(milligram)/3 ml(milliliter) (ipratropium-Albuterol) 1 vial inhale orally every 6 hours as needed for congestion; Nitroglycerin tablet sublingual 0.4 mg-Give 1 tablet sublingually every 5 minutes as needed for Chest pain X 3 doses. If no relief, call MD; Proventil HFA Aerosol Solution (Albuterol Sulfate HFA)-2 puff inhale orally every six hours as needed for COPD(Cardio Pulmonary Disease).  Review of R15's Medication Administration and progress notes shows she was not sent to the hospital upon her request. R15 was not given Nitroglycerin per physician orders for chest pains. R15 was not given either DuoNeb Solution or Provental HFA Aerosol Solution even though she "had a wet sounding cough" and "hard time breathing".  On 5/12/16 at 4:05 PM E4(Corporate Nurse) stated she had questioned the nurse who had taken care of R15 on the early morning shift of 3/18/16 because there were concerns. E4 stated she was a nurse and she had asked the nurse why the Nitroglycerin or Nebulizer treatments had not been given or why R15 had not been sent to the hospital when request. E4 stated the nurse in question could not provide E4 with any answers to these questions. When asked E4 if the nurse that provided care to R15 on both of these occasion was still working at the facility, E4 stated no. When questioned E4 why the nurse no longer worked at the facility, E4 stated the nurse was terminated for not following facility policy and procedures. E4 stated the nurse should have assessed R15 when she saw her having issues with Shortness of breath. E4 stated it was not the CNA's responsibility to follow up after the nurse had given the antacid and the nurse should have followed up because the CNA's are not qualified	S9999			



Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006118</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/13/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>METROPOLIS REHAB &amp; HCC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2299 METROPOLIS STREET METROPOLIS, IL 62960</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8  to do this. E4 stated if a resident is having problems with shortness of breath then the nurse should listen to their lungs. E4 stated if a resident is complaining of chest pain then a more thorough assessment needs to be done.  On 5/12/16 at 4:10 PM, E13 ADON(Assistant Director of Nursing) stated she had been on call the night/early morning on 3/18/16 when the nurse on duty had called her to make her aware R15 had been sent to the hospital and expired. E13 stated she had reviewed the incident and stated as a RN(Registered Nurse) she was not sure why R15 had not been sent out or why the nitroglycerine were not given. E13 stated R15 could tell you what she needed and wanted.  Review of R15's pulse summary from 8/11/15 to 3/17/16 shows no issues with R15's pulse until 3/17/16 at 2:30AM of the irregular 56.  Review of R15's Respiration Summary from 8/11/15 to 3/18/16 shows no issues with R15's respirations being higher than normal until 3/18/16 at 2:31 AM when it was 24.  R15's Plan of Care with initiation date of 8/21/15 shows resident has altered cardiovascular status related to Congestive Heart Failure, Hypertension, Peripheral Vascular Disease and the goal is resident will be free from sign/symptoms of complications of cardiac problems through the next review date of 5/18/16. Interventions include Assess for shortness of breath and cyanosis every shift; Monitor and report to MD changes in lung sounds on auscultation, shortness of breath; monitor and report to MD as needed any sign/symptom of Coronary Artery Disease: Chest pain or pressure	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006118</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>05/13/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>METROPOLIS REHAB &amp; HCC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2299 METROPOLIS STREET METROPOLIS, IL 62960</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	Continued From page 9  especially with activity, heartburn nausea and vomiting, shortness of breath; monitor pedal pulse to right foot as needed with care and concerns; Vital signs as needed. Notify physician of any abnormal readings. According to same plan of care, R15 had history of asthma and Cardiopulmonary Disease and the goal was resident will display optimal breathing pattern daily. Noted interventions are: Give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness; Monitor and report to MD as needed any sign/symptoms of respiratory infection: increase sputum (document the amount, color and consistency), chest pain, increased difficulty breathing, increased coughing and wheezing; Monitor for signs/symptoms of acute respiratory insufficiency: Anxiety, confusion, restlessness, shortness of breath at rest, Cyanosis, Somnolence  2. R3 is a 92 year old resident with diagnoses that include Alzheimer's, Dementia with Behavioral Disturbance and Delusional Disorder, as noted on the May 2016 Medical Review Report. R3's record included 2 documents from the pharmacy, titled "Drug Interaction Information", with dates of 2/9/16 and 3/7/16. Both documents indicate that R3 was receiving Diltiazem which may interact with another medication- Quetiapine Fumarate, that R3 was also taking. The documents indicate that there is a risk for adverse interaction at a Level 2- Severe Interaction, when these two drugs are used concomitantly.  As of 5/12/2016, R3 was continuing to receive these two medications at the same dosage as when the pharmacy addressed the concern. There is no indication in the record that Z3, R3's	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006118</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>05/13/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>METROPOLIS REHAB &amp; HCC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2299 METROPOLIS STREET METROPOLIS, IL 62960</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	Continued From page 10  Primary Care Physician was made aware of this risk as recommended by the consulting pharmacy. On 5/13/2016 at 11:00 am, E2-Interim Director of Nurses, verified that Z3 had not been notified of the drug interaction risk, prior to 5/13/2016.] (AA)	S9999			

## **IMPOSED PLAN OF CORRECTION**

Metropolis Rehab & HCC  
Annual Health Survey  
DATE OF SURVEY: May 13, 2016

300.610a)  
300.1010h)  
300.1210b)  
300.3240a)

### **Section 300.610 Resident Care Policies**

- a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

### **Section 300.1010 Medical Care Policies**

- h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

### **Section 300.1210 General Requirements for Nursing and Personal Care**

- b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

**Attachment B**  
**Imposed Plan of Correction**

## **Section 300.3240 Abuse and Neglect**

*a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)*

### **This will be accomplished by the following:**

1. Conduct an in-service on the following: Physician notification, change in condition, possible drug interactions and assessment/vitals skills.
2. The facility will conduct an investigation of needed training. Take appropriate actions to see that employees involved will receive education and training as needed regarding Physician notification, change in condition, possible drug interactions and assessment/vital skills.
3. Each employee whose duties might include direct care of residents who are at risk shall provide a return demonstration of the skills covered in the above in-services not more than ten days after the in-service. These demonstrations shall be monitored by the facility's Director of Nursing Services who shall maintain documentation of staff performance.
4. Any new facility employee will be required to review the in-service and demonstrate competency prior to being allowed to care for residents who are at risk without direct supervision.
5. Mandatory in-services shall be conducted with all care staff to address, at minimum, the following items:
  - A. Proper review, documentation and implementation of facility's policies and procedures and guidelines for Physician notification, Change in condition, Possible drug interactions and Assessment/vital skills.
  - B. Performance and documentation of assessments/vitals when a resident complains of chest pain, shortness of breath or any other complaint that may place resident at risk for harm.
6. The DON shall be responsible for making periodic observations of resident direct care, re-in servicing staff as necessary, and documenting any problems observed and corrective action taken.

7. The Administrator and Director of Nurses will monitor Items I through VI to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Within ten (10) days of receipt of this plan of correction.

6/30/2016/LJK